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ABSTRACT

Two-thirds of all schools in the United States are rural and three-fourths are small. Statistically, most teenage parents are from such school systems. Yet the problem of teenage pregnancy is most frequently overlooked by rural and small school communities. In fact, some cultural factors and resource deficiencies of these communities actually facilitate early pregnancy. The emotional, educational, and medical effects of teenage parenting are particularly serious for our society as a whole. The problems involved with teenage parenting must be recognized and comprehensively and holistically addressed by our society. Solving these problems in sparsely populated rural communities that typically have conservative attitudes toward sex education is an exciting challenge. Comprehensive efforts designed to enhance student self-esteem and to provide sex education; career, health, academic and mental health counseling; and alternate social activities, and that facilitate parent-child communication will prevent most teenage pregnancies. These efforts will strengthen the physical, mental, and economic health of the rural community involved. The project planning and implementation process itself will strengthen the sense of community. (Author/ABL)

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PREVENTING TEENAGE PREGNANCIES IN RURAL AMERICA

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ABSTRACT

Two-thirds of all U.S. schools are rural, and three-fourths are small. Statistically, most teenage parents are from such school systems. Yet the problem of teenage pregnancy is most frequently overlooked by rural and small school communities. In fact, some cultural factors and resource deficiencies of these communities actually facilitate early pregnancy. The emotional, educational, and medical effects of teen parenting are particularly serious for our society as a whole. The problems involved with teen parenting must be recognized and comprehensively and holistically addressed by our society. Solving these problems in sparsely populated rural communities that typically have conservative attitudes toward sex education is an exciting challenge. This article describes problems and community-based solutions specific to rural areas.

PREVENTING TEENAGE PREGNANCIES IN RURAL AMERICA

A. Problem Statement

The need for effective programs to delay sexual activity and prevent pregnancy has never been greater. Rates of sexually transmitted diseases (STDs) are higher in adolescents than in any other age group. In 1988, Shalwitz reported that 2.5 million American teens or 1 in 7 would be diagnosed with some type of STD (Shalwitz, 1988). U.S. teens under age fifteen are 15 times more likely to give birth than their peers in any other western nation (Buie, 1987). More than half of America's high school students report having sexual intercourse by the end of the twelfth grade. Over 25% of female teenagers (over one million or 1 in 10 each year) have experienced pregnancy (Kenney, 1987; Shalwitz, 1988). While abortion ends almost half of all pregnancies among teens 15-19, over 300,000 girls age 18 or younger become mothers each year (Nash and Dunkle, 1989). In fact, one-sixth of all babies born in the U.S. are born to teenage mothers, and 96% of these mothers keep their babies (Jolidon, 1989; Samels, 1988).

Contrary to popular opinion, the majority of teenage mothers are not minority women in inner cities. There is an increased use of contraception by teens, and the sexual activity rate which had markedly increased during the 1970s has stabilized (Kenney, 1987). Because the sexual activity rate of white teenage populations has increased faster than that of Black populations, the actual teenage birth rate has continued to escalate (Kenney, 1987). Well over half (61%) of all teen mothers are white and most are from rural or small school areas (Jolidon, 1989).

The rate of teenage mothers who are not married is also continuing to climb. As teenagers are now more aware of the high failure rate of teenage marriages and the problems of adolescent parenting, fewer are choosing to marry, even when that is an option available to a pregnant teenager. Jolidon (1989) reported that 70% of all teen mothers are remaining single.

The problem is well recognized at all levels of the school system. For example, a survey by the Education Research Group reported that more than half of 716 administrators surveyed in a national study favored providing students with "birth control" as part of comprehensive

school-based services. Yet 96% of U.S. school districts do not provide birth control, according to the survey. The vast majority of schools have not begun to develop comprehensive plans to deal with the problems of teenage pregnancy or teenage parenting. School administrators simply do not want to broach a subject with such potential to inflame parents and communities.

In spite of the fact that over 40% of all girls who drop out of school give pregnancy or early marriage as their reason, most principals (83%) either never or only sometimes mention pregnancy when discussing school dropouts (Nash and Dunkle, 1989). In a 1989 national study, only one in three schools reported that efforts to keep students from dropping out of school always or usually include a focus on teen pregnancy and parenting. Two-thirds stated that dropout prevention efforts never or only sometimes include teen pregnancy and parenting (Nash and Dunkle, 1989).

In a recent national survey of sex education teachers, 80% said that they need more assistance in teaching how to prevent pregnancy. School counselors state that high school motherhood is part of the teenage lifestyle of risk-taking. Because sexual images and references are commonplace in today's society, educators view moral values as "crumbling" (Jolidon, 1989).

Parents also increasingly appreciate the need for schools to teach their children ways to prevent pregnancy and sexually transmitted diseases, including AIDS. In a recent Lewis-Harris poll (Harris, 1988), 95% of adults indicated that teenage pregnancy is a serious problem and 89% favored sex education in the schools. A full 73% supported making birth control information and contraceptives available in school clinics. Of course, these parents also want their children to know that abstinence is the only completely safe form of pregnancy prevention and how to avoid sex.

Students also recognize teenage pregnancy as a concern. Sexual issues were reported by 17% of junior high respondents in a national survey as their top concern, second only to drugs and alcohol (*U.S.A. Today*, 1989).

B. Effects of Teenage Pregnancy

Teen pregnancies are difficult for a variety of reasons. While 47% of pregnant teenagers give birth, 40% get abortions and 13% have miscarriages (Kenney, 1987).

Teenage pregnancy presents a number of medical, educational, legislative, emotional, and social problems. Medically, adolescent mothers tend to have higher incidences of pregnancy complications, more premature births, and greater numbers of low weight and/or less healthy babies requiring more extensive and expensive medical care (Buie, 1987). The teen mother herself may be less healthy than her peers due to the physical and emotional stresses of early childbearing.

Generally, children born to teenage mothers are at a developmental disadvantage compared with children born to older mothers. In fact, Kopp and Kaler determined that teenage pregnancy has major implications for developmental disabilities, including mental retardation (Kopp and Kaler, 1989). The overwhelming majority of Down syndrome children have young parents (Scott and Carran, 1987).

Baldwin and Cain (1980) found that children born to teenagers suffer intellectual deficits, largely because of the economic and social impact of early childbearing on the young parents. Their literature review determined that all analyses indicated deficits in the cognitive development of children (especially male children) born to teenagers. They found that much, but not all, of the effect results from the social and economic consequences of early childbearing (Baldwin and Cain, 1980).

Small yet consistent differences in cognitive functioning between offspring of early and late childbearers appear in preschool and continue into elementary school (Broman, 1981; Maracek, 1979, 1985). These decrements are more likely to be observed in the sons than in the daughters of early childbearers. Psychosocial problems also may be more common in the offspring of teen parents (Ramey, Stedman, Borders-Patterson, and Mengal, 1978). For example, preschool children of teenage mothers are rated as being more active, aggressive, and as possessing less self-control than the children of older mothers. These cognitive and

psychosocial differences may set the stage for late school and social difficulties (Furstenberg, Brooks-Gunn, Chase-Lansdale, 1989).

Specifically related to rural ethnic populations (e.g., Native Americans, Hispanic migrants, and Southern Blacks), economically distressed ethnic teenagers often have low birth weight babies at rates that are three times higher than economically comfortable White women (National Center for Health Statistics, 1987).

The average teen mother has a second child before age twenty (Samels, 1988). In fact, the national average for teen mothers who have a one-year repeat pregnancy rate is 18-25% (Buie, 1987).

Educationally, pregnancy is the leading cause of female school dropouts. At least 40,000 quit school each year because they are pregnant, according to the Center for Population Options (Nash and Dunkle, 1989). Only half (56%) of all teenage mothers finish high school, and only 5% finish college (Jolidon, 1989; Buie, 1987). According to a survey by the Equality Center, in spite of the mandates of Title IX of the Education Amendments of 1972 (stating that schools cannot discriminate against pregnant teens), pregnant girls or teenage mothers typically do not receive the support they need to complete their education and are likely to experience discrimination at their school. In fact, one study reported that most teachers think pregnant or parenting students are morally or intellectually inferior (Nash and Dunkle, 1989; Kenney, 1987).

Regarding social costs, teen pregnancy tends to foreclose very important options in school and work. Many single parents have difficulty finding or keeping jobs, and related babysitting and transportation costs for single parents in rural areas can offer significant challenges. Dropping out of school is associated with lower earnings and increased welfare dependency later in life (Buie, 1987). Welfare is needed by 73% of teen mothers within four years, and half of all high school mothers are living in poverty by their mid-twenties (Jolidon, 1989). In fact, half of all AFDC (Aid to Families with Dependent Children) funds are awarded to households in which the mother was a teenager at the time of giving birth (Kenney, 1987). At least 25%

will stay on welfare for a prolonged period of time (Kenney, 1987). According to the National Research Council, the average teen having her first child at age fifteen will cost taxpayers $18,130 per year for the next twenty years (Buie, 1987).

The emotional strains of childbearing and infant care are especially difficult for adolescents who are themselves still maturing. The teen mother's self-esteem may be significantly lowered because of societal, family, and personal reactions to her experience (Samels, 1988).

Many teen mothers want to fulfill their role well and raise a happy and healthy child. Frequently their own emotional, intellectual, and social development has been stifled to the point that they consciously or unconsciously resent their child. Many teen mothers become pregnant a second time by the same father who previously abandoned them with their first baby.

The fact that the majority of pregnant teens are school dropouts makes them poorly equipped to be responsible parents to a new generation. Many are involved in low-pay, low-status jobs, or are unemployed (Kenney, 1987). Their children may also have diminished prospects for success in school and/or exhibit delinquent behavior (Furstenberg, Brooks-Gunn, and Morgan, 1987). Low birth weight children perform less well in school academically and score lower on standardized intelligence tests. Such children are also more prone to exhibit mild behavior disorders and to experience emotional problems. They are also more likely than other children to become teen parents themselves (Kenney, 1987; Furstenberg, Brooks-Gunn, and Morgan, 1987).

Legislatively, policymakers are unsure which approaches to fund. Schools and legislators tend to want to ignore teen pregnancy or wait until constituents demand that the problem be addressed. While research indicates that family life education and the use of contraceptives both have a positive effect on reducing unintended pregnancies, both remain highly controversial approaches in all parts of the U.S. (National Institute for Adolescent Pregnancy

and Family Services, 1988). Very few schools offer core courses for a pregnant teenager such as prenatal care, parenting, or even simple money management (Buie, 1987; Kenney, 1987).

Opponents of legislation on family planning argue that making contraceptives available to young people encourages them to engage in sexual activities. Legislators appear to be caught in the middle. According to the National Institute for Adolescent Pregnancy and Family Services (1988), the type of legislation usually introduced, including "parental consent" legislation, appears to be counter to effective prevention.

C. The Role of the Male

"Date rape" is common and is typically accompanied by shame. Thus, it is usually unreported and contributes to the lack of male accountability regarding teen pregnancy. Many males, at most, offer to help pay for an abortion and feel that this alleviates their responsibility. The teenage father remains largely ignored when the issue of teenage pregnancy is discussed. It has been difficult to obtain information on the fathers of babies born to teenage mothers. Few statistics are thus available, and men's roles are grossly overlooked.

The teenage father is often not included in any decisions about the pregnancy or in the rearing of the child. When he is involved, he often finds that he has to drop out of school and get a low-paying job in order to support his new family. He is suddenly faced with the huge responsibility of providing and supporting a family at a fairly young age. The pressures are often too much for him to handle. In recent years, in order to reach these teenage fathers, some programs have been introduced to help them cope with the situation (National Institute for Adolescent Pregnancy and Family Services, 1988). Unfortunately, very few of these services have been introduced in rural areas.

D. The Relationship Between Teen Sexuality and Level of Self-Esteem

School counselors report that low self-esteem is cited by many high school mothers as one reason they became pregnant. A mother's role--even ill-timed--is imagined to be an improvement over the pressures of teenage life (Jolidon, 1989). Many teens with low self-esteem consciously or subconsciously feel that, by having a baby, they will finally receive the

love they are not receiving at home and will then be a "worthwhile person" and belong to a "family" within the larger community. Teens who become pregnant are often acting out against a host of other problems, and some feel that a baby will be the one person in their lives who will offer them unconditional love.

The likelihood of a teenager becoming sexually active or becoming pregnant has less to do with socioeconomic status than with the individual teens' values, goals, aspirations in life, and the kind of family environment in which she is raised. However, the poorest, most vulnerable minority teens are disproportionately likely to carry a pregnancy to term and to keep the infant--possibly because teenagers from more affluent families can afford abortions while Congress continues to deny federal funding for abortion to low-income women, in all except life-threatening cases (Kenney, 1987).

Teens who feel a sense of hopelessness that they have no control over their lives do not exert their freedom of choice. In fact, one study of teen mothers reported that adolescents from dysfunctional families, economically or otherwise disadvantaged backgrounds, feel so little volition over the events of their lives, that they exert no more control over them than a "leaf falling from a tree." For such girls, having a baby is less a question of ignorance or choice than one of inevitability (Marek, 1989).

It is clear however, that teenagers (especially girls) who see a positive future for themselves are less likely to become sexually involved at an early age, are more likely to use contraception effectively if they do have sex, and are less likely to bear a child if they become pregnant. A 1982 Northeastern University study also identified a correlation between early parenthood and academic ability. Older teenage females with poor basic skills were 2 1/2 times as likely to be mothers as those with average basic skills. Older teenage males with poor basic skills were 3 times as likely to be fathers. Among younger teens--those under 16--females with poor basic skills were five times as likely to become mothers as those with average skills (Kenney, 1987).

National data clearly indicate a link between a teen's educational and economic opportunities and his or her decision regarding parenthood because of the disproportionately high pregnancy rates among low-income teens, including minority youths. Although teen pregnancy is a national problem affecting all races and all economic strata, the data show that low-income and minority groups--which can offer their young fewer opportunities--suffer the most severe impact (CDF Reports, 1986).

For example, children growing up in minority families (which are much more likely to be poor) are at a much higher risk of premature parenthood. Black and Hispanic youths account for only 27% of the nation's adolescent population. However, they account for about 40% of the teenage women who give birth. Furthermore, disadvantaged young women of all ethnic groups are 3-4 times more likely to be teenage parents than are advantaged teens. This fact compounds their risk of repeating the cycle by raising their own children in poverty (CDF Reports, 1986).

Clearly, all teens need real opportunities to grow into productive, self-sufficient adulthood. Only this will produce the motivation to delay sexual activity, pregnancy, and parenthood. Two of the most readily identified and important factors are education and employment opportunities (CDF Reports, 1986).

Our nation tends to judge a person's worth according to success with school, work, and family. It is not surprising that teenagers who see little hope of graduating from high school and going on to college or obtaining a steady full-time job have difficulty resisting the lure of parenthood. For many teens who find that other options are limited or non-existent, parenthood fills a painful void.

A recent study sought to identify factors that account for state-to-state differences in teen pregnancy and birth rates concluded that the broad social setting in which teenagers make--or fail to make--decisions about childbearing is extremely important in determining their chances of becoming pregnant, giving birth, or having an abortion. States in which the status of women is higher have lower teen birth rates and higher abortion rates. Politically liberal states have

relatively low rates of pregnancy and birth. States with large fundamentalist populations have higher birth rates. States with high dropout rates and larger proportions of young females not graduating from high school have higher pregnancy and birth rates and somewhat lower abortion rates (Kenney, 1987).

Another study that compared the U.S. with other developed western nations concluded that those countries with the most liberal attitudes towards sex, the most extensive sex education programs, and the most easily accessible contraceptive services, have the lowest rates of teenage pregnancy, abortion, and childbearing (Kenney, 1987).

Adolescents are typically egocentric, oriented to the present, have a sense of personal vulnerability, and are primarily influenced by their peers. Teen sexuality is loaded with embarrassment, shame, fantasy, insecurity, urgency, external and often conflicting pressures, and other complicating factors. Thus, knowledge alone is generally not of much help in real-life, spontaneous, emotionally laden situations. While only about one percent of teens are believed to use drugs intravenously (English, 1987; Paulk, 1989), a majority do use alcohol and/or other chemicals which can impair judgment and delay emotional maturation (Shalwitz, 1988; Rotheram-Borus, Koopman & Paulk, 1989). Keller et al. (1988), found that sexual activity and drug use were positively associated in a teen cohort, regardless of age. The recent increases in teenage drug and alcohol use in the U.S. indicate that the potential societal effects of high teen pregnancy statistics are serious.

E. Problems with Existing Teen Pregnancy Prevention Programs

A great deal of research has been conducted on pregnancy prevention programs. Jorgansen (1981) and Paulk (1989) cited a formidable array of barriers to the effectiveness of pregnancy prevention education with teens. These include teens' own levels of cognitive development, traditional sex role perceptions, parental lack of involvement with educational efforts, and the negative effects of mass media on the sexual socialization of youth. In the face of these and other barriers, it is not surprising that most school pregnancy prevention

programs have been shown to be, at best, minimally effective (Kirby, 1984; Zelnik & Kim, 1982; Paulk, 1989).

Teen pregnancy prevention programs typically address males and females separately or exclude males. Few curriculum resources address males, and none use rural delivery systems. When males are approached, it is usually from an intellectual point of view (e.g., information receiving) vs. a behavioral or attitudinal point of view.

According to the Men's Reproductive Center, the relatively few male involvement projects across the U.S. usually have not lasted more than three years. Funding agencies typically either do not initially fund them or they prioritize care programs for pregnant mothers and do not re-fund mens' programs.

One of the most difficult problems is that educators experience a great deal of pressure to cover academic content, generally in full classrooms, in an era in which the success of U.S. education is consistently being challenged. Each year, in the last decade, educators have been mandated to raise standards and add new curriculum ranging from career education to values clarification and HIV education. Educators are sometimes resistant to words infusing sex education curricula, are not comfortable teaching sex education, and/or do not want to be known as a "sex educator" in the local community.

F. Success Factors in Pregnancy Prevention Programs

Paulk (1985) found three factors which appear to facilitate the success of pregnancy prevention efforts. First, the program should be long enough to effect significant, lasting change. Second, the program should be comprehensive, dealing with as many as possible of the varied issues surrounding pregnancy prevention and sexual risk-taking. These issues include sexual and contraceptive knowledge, self-esteem, decision-making skills, and assertiveness skills. Finally, the program should involve students, both intellectually and emotionally, in the learning process (Helge and Paulk, 1989).

Most teens wait one year after becoming sexually active before seeking sex education, counseling, or medically supervised contraceptive care. Thus, almost one-half of teen

pregnancies occur within six months of an adolescent's first sexual encounter. (Kenney, 1987.) Shortening the delay between the first intercourse and use of effective contraception could reduce teen pregnancy rates significantly.

Significantly impacting sexual risk-taking behavior is difficult, and designing and implementing effective programs requires commitment and creativity. Effective programs require prevention and care services involving every available and appropriate community agency. Male roles must be addressed in terms of sexual issues and contraception. Males and females must understand that to avoid pregnancy, they must abstain from sex or use contraception consistently and effectively. Many youth will be most comfortable abstaining from sex. Others must learn the risk of pregnancy, what to do to abstain or contracept, and how to manage social situations so they can.

Youth who engage in open, honest communication with their parents (less than 15% of all adolescents) are more likely to succeed in delaying onset of intercourse and/or have protected intercourse (Shalwitz, 1988). The family life education young people receive in schools, youth groups, churches, and medical facilities will enhance and reinforce their fund of knowledge and safe(r) sex practices. Youth services providers such as youth group leaders, educators, coaches, therapists, and health care providers have the task of continuing to support and educate these teenagers while addressing the needs of the other 85%. Because such youth services providers are as heterogeneous as the young people they serve, some of them will be comfortable discussing issues related to sexuality, pregnancy, and sexually transmitted diseases and some will not. Therefore, it is important that each worker/clinician and agency examine its appropriate scope and limitations in dealing with teen pregnancy prevention. Once the role is determined, education, training, and support must be undertaken to ensure success.

The last decade's experience with sex education has clearly revealed that didactic "one shot deals" are ineffective in changing teenage sexual behaviors. Successful pregnancy prevention strategies include the following components.

* Information and messages communicated to teenagers must be accurate, brief, explicit, and direct as well as consistent and repetitive. Judgmental and ambiguous terminology should be avoided. Because of the serious nature of the material, humor and engaging presentations are often greatly appreciated. Service providers must be patient and tenacious as messages may need to be articulated a number of times before they are heard.

* Youth respond most positively and are most interested when they hear a message from a person they trust. This may be a parent, friend, counselor or youth services worker. It is thus of critical importance that service providers understand the social norms and values of the targeted population. Activities and materials must be culturally, educationally, linguistically, and developmentally appropriate and sensitive. Any audio/visual aids must be realistic for the teen target population, if they are to be believable.

* Teenage pregnancy must be discussed within the context of the broader societal/family life issues young people experience. Education must incorporate skills development concerning values clarification, self-empowerment, conscious decision-making, communication and decision-making skills, assertiveness training, and responsibility for one's own actions. These features should ideally be integrated into a comprehensive family life education program that includes but is not limited to: cultural values and norms, anatomy and physiology, sexual development, pregnancy, sexually transmissible diseases, contraception, parenting, substance abuse, and self-esteem education.

* Teenagers and their families should be involved in the design and implementation of activities and programs. The positive power of peer pressure and support should be capitalized upon. Indigenous outreach workers, peer counselors, and parent trainers should be adequately trained and used wherever and whenever feasible, whether in schools or in community-based sites.

* All staff and administrators associated with youth programs should be trained and educated at regular intervals regarding the state of teen pregnancy in the nation and the region, sexually transmissible diseases, and other relevant issues. Staff should be knowledgeable with the lifestyles and language of the youth with which they interact. Youth service providers should be trained experientially so that they feel and process their own emotions concerning sexual issues and practice discussing/presenting sensitive matters to youth.

* Educational and counseling activities should be flexible in method and varied according to the service site (e.g, outreach agency, school, church, social club, etc.).

* As much as possible, teenage pregnancy prevention activities should be integrated into a comprehensive, coordinated service delivery system to youth. All appropriate and accessible school, medical, psychiatric, and support resources should be identified and used, particularly for youth who are "at-risk." Resources should be affordable (preferably free), confidential, and developmentally appropriate.

* Staff should never assume that teenagers know how to correctly use any birth control devices that are discussed or disseminated. Contraceptive education is most effective with a visual demonstration using anatomically correct models, rather than an oral presentation.

* All prevention and counseling programs should be regularly evaluated for effectiveness and modified according to the most recent information available concerning the target population.

(Shalwitz, 1988)

Pregnancy prevention programs typically combine traditional methods of prevention, sexuality education and access to contraceptive techniques. These are structured with the view that providing information will help delay the first intercourse and prevent pregnancy.

Experience with attempting to reduce teen pregnancy during the past 20 years has proven that simply providing sex education and access to contraceptives for teens is not enough to prevent them from getting pregnant (Hutchins, 1989). Yet we know from surveys of teens who do not get pregnant that they are the teens who have ambitions for the future and resources, skills, and backgrounds to realize their plans.

The psychological dynamics of individual teenagers, heavily influenced by the mass media and social pressures, mandate the recognition that self-esteem education has been the "missing link" in most pregnancy prevention programs.

Effective programs provide access to reproductive health services and provide peer and professional counseling emphasizing abstinence. Skill building activities are an integral part of such programs. They include parents and other family members and involve boys at every age level. They include activities designed to increase parent/child communication about sexual matters.

We, as a society, must enhance out teenagers' lives so that they have incentives not to be teen parents. This will require improvements in education, job training, and community development. Teenagers must understand that they not only have realistic hope for a positive future, but that they control their own lives and are accountable for them. It is critical that they understand their ability to choose their future. Particularly for students with low self-esteem and/or from disadvantaged backgrounds, they must develop the ability to love and nurture themselves, to offer themselves unconditional acceptance, and to identify peer groups that will assist in their growth (even if their families are non-nurturing).

Effective after-school and summer programs for young adolescents improve basic skills and prevent pregnancy. Economic empowerment/youth employment programs prevent pregnancy. These include school to work transition, out of school remedial education, and community-based service organizations or activities. Policy and program coordination are essential.

The motivation to avoid teen parenthood comes from the availability of experiences and opportunities designed to enhance the individual's self-esteem and to develop his or her individual skills. The capacity to avoid pregnancy comes from sex education, the availability of contraceptives, assertiveness training, peer and professional counseling, and other appropriate services.

G. Why Teenage Sex is Common

The American emphasis (including through the media) on acceleration of teens into adulthood and the view that sexual activity is part of the passage into adulthood is one reason many teens choose to engage in sexual activity at an early age. Surveys have indicated, however, that sex is not the main consideration in teenage dating. More important to boys is companionship and to girls is communication. Teens appear to have a difficult time separating sexual affection from other kinds of affection (*U.S.A. Today*, D-1, January 20, 1989). It is essential that schools teach communication skills and the difference between intimacy and sex.

Clearly, primary causes of teenage pregnancy include ignorance, poor sex education, feelings of hopelessness/lack of choice in one's future (depression), poor school performance, depression, low self-esteem, being from an alcoholic/dysfunctional family or from a broken home, lack of parental supervision, school adjustment problems (particularly early grade problems or transition problems from elementary to junior or senior high school), or being a school dropout (Samels, 1989). Many of these factors are interrelated and some (such as poor self-esteem, living in a dysfunctional family, and poor academic performance), may be causal (Samels, 1989; Helge, 1988).

H. Sex Education, In Isolation, Is Not a Deterrent

The American culture is greatly influenced by the popular media--television, videos, movies, radio, and magazines. Most media vehicles promote sex as romantic and exciting but seldom address the responsibilities of sexual relationships, contraceptives, or the consequences of early parenting. Many U.S. teenagers have been raised in single-parent households or in families where both parents work. Many have been left to fend for themselves at an early age, and their role models are images they see on television and videos (National Institute for Adolescent Pregnancy and Family Services, 1988).

Many students are afraid their parents will think ill of them if they discover that they are using birth control. Thus they continue to take unnecessary chances. Shalwitz (1988) reported that among sexually active females, 15-19 years, two-thirds reported no use (or ineffective use) of contraception. Less than 15% used a condom at their last intercourse.

Although ignorance is responsible for some teenage pregnancies, sex education is not a sure deterrent. In fact, research has repeatedly shown little correlation between participation in a *unit* on sex education and level of sexual activity (Buie, 1987). Simply incorporating a unit on sex education into other coursework may increase students' knowledge, but it rarely changes behavior (*U.S.A. Today*, D-1 & D-2, May 16, 1989). Sex education must be expanded beyond a one- or two-week session in high school to become, instead, part of a twelve-year learning program with a broader agenda that includes encouraging young people to set long-term goals and to think beyond the present.

Research has clearly indicated that school sex education programs do not lead teens to delay sex, use birth control, or avoid pregnancy. Teen's sexual mores are molded instead by television, films, music, advertising, peers, and adult models (*U.S.A. Today*, D-1, April, 1989). At most, schools typically offer a few weeks of scattered lessons, and the majority of those teaching these lessons are not qualified personnel. Because sex is not an isolated behavior, effective sex education must be part of an overall health approach (*U.S.A. Today*, April, 1989).

Classroom programs must be supplemented by community-based efforts involving parents, churches, youth groups, and the media.

I. Problems Specific to Rural Areas

Two-thirds (67%) of U.S. schools are rural. This is a vast constituency. According to a number of surveys (*U.S.A. Today*, D-1, January 20, 1989; Jolidon, 1989), rural teens are as sexually active as their non-rural peers. In fact, a study conducted by the Rural Adolescent Pregnancy Project found that 40% of the teenage girls in rural northeastern Connecticut would become pregnant, and 18-20% would give birth. Jolidon (1989) reported that contrary to popular opinion, most teenage mothers are located in rural settings.

Rural schools are the least likely to offer sex education to their students (Helge and Paulk, 1989). Frequently, rural communities with traditional value systems resist sex education. Schools which do provide it, frequently lack appropriate curriculum or resources to secure such materials. Many rural school districts lack qualified health educators or other teachers who are comfortable with sex education and being known as the community "sex educator." Many rural schools do not offer health education, and those that do frequently limit it to 20-40 minutes per week. Because of this time limitation and community resistance to sex education, it is not usually integrated into health education as it typically is in non-rural schools.

Even with HIV education mandated by many states, rural sex education is typically minimal. For example, a national survey of 100 randomly selected rural schools in the U.S. indicated that while 80% of respondents stated that their schools provide some form of mandated HIV education program, 90% permit parents to excuse their children from this education (Helge & Paulk, 1989). Most programs (59%) took place in one day or less, and most HIV education programs are provided in upper rather than lower grades. Most importantly, barely half (54%) of the 100 schools responding to the survey, stated that they had even minimal activities directly related to pregnancy prevention. This means that sex education lessons were of an even shorter span than in non-rural areas and were oriented specifically toward HIV education because of state mandates. Almost one-third (29%)

specifically asked for assistance with establishing and/or implementing a teen pregnancy program. The survey indicated that most of the programs did not meet the criteria described earlier as essential for an effective sex education program (Helge & Paulk, 1989).

The prevalence of at-risk students in rural areas of the U.S. is high (Helge, 1988). The extent of the problem can been seen in the Wyoming Department of Education's statement that as many as half of that rural state's children could be classified as at-risk in terms of their potential for pregnancy, dropping out, suicide, drug addiction, abuse, crime, or illiteracy (Catherman, 1987).

Rural areas typically have disproportionate percentages of students from poor families. According to Rodgers and Burge (1982), 30% of the farm population and 24% of the non-farm population live in poverty. Many rural communities are composed of Hispanic migrants and other non-English speaking populations or other minorities such as Southern Blacks and Native Americans. Many of the factors associated with teenage pregnancy such as poverty, dysfunctional families, poor economy, isolation, alcoholism, lack of parental support, high dropout rate, low student and adult aspirations, low peer and parental expectations, greater acceptance of early marriage, lack of economic opportunities, and limited available social activities, are more prevalent in rural areas (Helge, 1988).

Teen pregnancy is closely linked with low self-esteem and rural rates of poverty and other disadvantages, described above, are disproportionately high in many rural communities. Successful role models are frequently limited--particularly successful female role models. There is also typically little, if any, qualified counseling concerning personal development issues or individual counseling concerning sexual issues. This is particularly true for students in areas in which a small town with many social and economic problems offers a safe familiararity and students are afraid to venture outside or move elsewhere.

Health and mental health resources are frequently absent in rural areas, particularly those that are geographically remote or isolated. Community mental health resources are also inadequate in rural areas of the U.S., and the comprehensive roles of well-trained school

psychologists are frequently misunderstood or under-utilized in rural schools. Qualified rural psychologists are difficult to recruit and retain in rural areas, and they are frequently unaffordable for rural schools. The majority of rural schools do not employ school counselors, largely for financial reasons. Psychologists and counselors, when available, frequently spend a majority of their time conducting standardized tests or designing class schedules, versus counseling individual students or groups (Helge, 1988).

Because rural citizens are typically very aware that they must "live with their neighbors," many incest and other sexual abuse is unreported in rural areas. All of these factors contribute to high rural teenage pregnancy rates.

Teen pregnancy is sometimes accepted in the rural junior high or middle school. Sexual activity frequently begins in elementary school, especially in impoverished areas. Rural schools do not have the resources of urban and suburban schools for school-based programs (e.g., family planning clinics). Traditional rural attitudes generally prohibit them. In fact, data collected from rural schools field-testing HIV education curriculum modules for the National Rural and Small Schools Consortium's national HIV education project indicated that they only selected curriculum that was "appropriately traditional, conservative, and emphasized abstinence." Most rural districts were offering sex education only because of state HIV education mandates.

A majority of rural communities do not have planned parenthood and related agencies geographically accessible to them. Youth-serving agencies such as boys clubs, YWCAs, and YMCAs are nonexistent in many rural communities. Established agencies such as cooperative extension (county agricultural agencies) or 4-H clubs are generally not tapped by schools as sex education resources. Male reproductive health concepts and resources are virtually unknown in rural America.

A teenage pregnancy prevention theme is generally lacking in rural areas. Most grants or other programs available to rural areas emphasize services to pregnant teens vs. prevention. Only a small number of programs across the entire U.S. involve males. Preliminary findings

regarding school-based clinics that provide birth control reveal a decline in teen pregnancy (*U.S.A. Today*, April, 1989). Such clinics follow an urban model. There are simply not enough students in sparsely populated, isolated rural areas to merit such an approach. In fact, a comprehensive literature review revealed that most innovative pregnancy prevention projects are metro-oriented and are not easily adaptable for sparsely populated rural areas. (E.g., New York City and New Orleans traveling theaters; Oakland's programs of meeting boys at major sports events and taking them to planned parenthood clinics). While the National Urban League sponsors programs in more than 70 cities to prevent and deal with teenage pregnancy and over 100 schools across the U.S. have school-based clinics, rural areas definitely lack effective program approaches.

J. Rural-Oriented Approaches

Rural-oriented approaches are definitely needed. Approaches that will work will include sex education curriculum palatable to local community values and mores, sex education support from local community organizations and parents, educational approaches consistent with community values, alternate social activities and reward systems for teens, qualified sex educators or other teachers who are comfortable with sex education and with being known in the community as a sex educator, and successful role models.

Successful program planning will account for the fact that rural communities are extremely heterogeneous depending on their economic base and social cultures. Approaches to be used must incorporate career counseling, vocational training, and involvement of parents, churches, youth groups, and media. Rural communities do have a number of unusual resources that generally have not been effectively used. For example, since citizens in small, rural communities typically care about each other and neighbors help neighbors, extended families and existing outreach systems should be used. This would include the cooperative extension service (county agricultural agencies), 4-H, public health educators, and outreach personnel such as bookmobiles, mail carriers, and meter readers.

An illustration of the unique strategies required to implement teen parenting prevention programs in rural schools is the involvement of county extension personnel. They are "out and about" in the local community, know everyone, and are selected for their positions because they are respected citizens and thus listened to. Other examples of parties to be educated and involved for effective programs are extended families (more prevalent in rural areas), and other "natural outreach systems" such as those mentioned above. These types of providers have a natural communication system that is highly effective. The local communication and power structures must be acknowledged and effectively used. (E.g., the one gas station attendant in a remote rural area talks to lots of folks each day and can change opinions. The clerk at the one grocery store in a rural areas is another resource.)

Most such individuals are well respected in the local community and can make or break a project. It is also critical to involve local social organizations no matter how few and how small they may be. For example, the garden club could show a film concerning the prevention of teen pregnancy as its monthly program. The 4-H club, a county extension meeting, the Grange organization, VFW, the wranglers riding club, and local churches could do the same.

Strategies for preventing teenage pregnancy in rural areas will best be implemented by local personnel who feel that the change is at their initiation or, at least, addresses a perceived need of theirs. Any social organization, informal or formal, can be a vehicle for implementing a pregnancy prevention program. If rural citizens feel that the project is relevant to the community, and if they are involved in designing and implementing the project, it will be more likely to be implemented. Local organizations are essential for school pregnancy prevention programs to be successful. Significant change will most likely occur with approaches that are holistically and experientially based, and take the time to process information, versus those that assume that a cognitive "one shot" curriculum approach will produce change in the adolescent's behavior.

Pregnancy prevention must include more than sex education information transmission. It must include decision-making, communication skills, and self-esteem education. Teenagers

with high self-esteem will care enough about themselves and others to make decisions to improve their future rather than unnecessarily place themselves at risk.

It is clear that self-esteem education must be infused across all aspects of pregnancy prevention programs. This design is necessary so that students have both the strength and the knowledge to abstain from early sex, or at least, to experience safe(r) sex. This cannot occur within a few hours. Accomplishing this in conservative, under-funded rural schools is an exciting challenge.

K. A Rural Model

Neither schools nor parents can solve the teen parenting problem alone. The first step will be the community's acknowledgement that teen parenting is a community-wide problem requiring a community-based solution. A key facilitator--a highly motivated individual or organization--must be identified and accepted by the community's critical communication and power sources and by school personnel. This person must receive any sex education training necessary for the individual to feel confident with the role and comfortably discussing sexual issues and other topics related to teenage pregnancy prevention.

Information for the community's project development should be gathered including the number of school dropouts during a recent time period (e.g., ten years), and the relationship of this number to the number of teen parents in the local community. (The facilitator should keep in mind that nationally, 40% of all school dropouts are teen parents.) Key community groups should be informed of statistics such as the fact that for every teenager above age fifteen giving birth, statistically there have been 2 pregnancies; for every teen below age fifteen giving birth, there have been 3 pregnancies. Most teenage pregnancies are unreported. (Adams, 1989.)

Community resources for planning and implementation should be identified. A highly motivated planning group should be selected, and most of these members should be volunteers. This group should meet as frequently as necessary to identify its goals for the project and to emphasize that this is a community-wide priority and project. Local news media and natural

communication systems in the local rural area should be used to publicize relevant activities of this group and its enthusiasm about the project. Meetings of the planning group should be open, and community members who are not officially part of the group should be invited to attend and give suggestions. Their input should be considered by the group in a format that will facilitate total community involvement or at least support for the project.

The community's existing resources and services should be compared by this community to "model" resources and services. This model will involve goal setting by the planning group. The goals, or "standards" for performance of the program will be developed after reviewing "model" resources and services. These activities will assist in pulling together community resources. Goals of the planning group should include designing a system where an individual teenager's needs will be responded to individually and confidentially, by a coordinated, unified rural community system.

All teenagers should be seen by the planning group and by the local community as "at-risk" for teen parenting. Publicity should be circulated within the planning group and the greater community regarding the fact that there is no stereotype of a pregnant teenager or a teenage father. All socioeconomic groups, with all value systems and lifestyles across America, have teenage parents in their families.

The planning group should also design a process whereby students who are at a higher than average risk for early pregnancy should be identified at an early age (at least by junior high school). This should be done by a non-judgmental process. All efforts should be made to protect confidential information about the teenagers involved and their families.

The identification of students who are considered highly "at-risk" by the committee should be objective. Students that should be considered include those who have involvement with crime, substance abuse, frequent depression, child abuse, poverty, dysfunctional or alcoholic families, and illiteracy. Students who are migrant workers, school dropouts, or who are both minority and poor should be considered. Discussions surrounding identification of such students should always be prefaced with the comment that across America, a vast majority of

teenagers are sexually active. Thus, all teenagers are statistically at risk for being teenage parents.

Community resources should be assessed including counseling, education, health/planned parenthood services, other related social services, volunteer group activities, career counseling, vocational training, sex education, and any school sex education programs.

Other community resources to be identified should include relevant local clubs or youth organizations, rural outreach agencies (e.g., county agricultural agencies, public health educators, 4-H), interested non-judgmental parents, and churches.

Community planning should specifically detail approaches to take in the schools and via all of the organizations identified. Curricular materials and other information and methodologies should be infused into ongoing educational, social, and spiritual development activities. Individuals and agency personnel who will be involved should be trained and should give and receive peer feedback regarding their abilities to be non-judgmental and effective with teenagers. Individuals and agency personnel to be involved should be familiarized with all available community resources, model programs, curricular materials, and other information and methodologies.

As educators in rural settings have typically resisted sex education, this role should not be thrust upon them. The purpose is for the program to be effective. It is perfectly acceptable for the local community planning group or its facilitator to tell educators that it is understood that their job descriptions do not typically include sex education and that they may not be comfortable with a sex education role. On the other hand, they need to understand that teenage sexual activity is affecting their ability to educate students.

School personnel should be allowed to perform roles that are comfortable to them, and community resources should be recruited to assist with other teenage pregnancy prevention roles. For example, teachers can use their established relationships with students to welcome visitors to the classroom who will deal with topics with which the teacher is uncomfortable.

These visitors might include teen parents, other parents, therapists, regional planned parenthood agency personnel, ministers, public health workers, doctors, and others.

Educators need to understand that they are not expected to be therapists and that it is understood that they have not been trained to conduct therapy. On the other hand, identified lists of competent mental health professionals should be made available so that they can lead individual or group discussions with students regarding psychodynamics of adolescent choices. For example, it should be openly discussed with teenagers that sexuality is viewed by our society as a rite of passage into adulthood and that getting pregnant may be seen by the teenager as part of becoming an adult. Honest discussions also need to occur regarding sexually transmitted diseases. Dialogue should acknowledge the fact that some teenagers subconsciously decide to become pregnant so that they are not faced with their uncomfortable fears about growing up and becoming responsible.

A critical variable for school personnel is that they should be reinforced for what they do well and know that community resources are available to perform functions for which they are not trained, comfortable, or motivated to accomplish. The pregnancy prevention roles that they do have should be clear.

Program implementation should be publicized in a positive way on an ongoing basis. Formative evaluations should be planned as all program activities are designed. Evaluation should be implemented so that the program can make necessary modifications on an ongoing basis. The total effort should be seen as an experience that is developmental, and evaluations should be viewed as essential to the program. The evaluation methodology should be consistent with the model resources and services discussions that occur early on in planning of the program.

L. Conclusion

Teen pregnancy occurs at an alarming rate across rural America, and rural schools and communities are not effectively dealing with the social and other effects of this problem. Community-based solutions that are comprehensive and holistic in nature will prevent many

teen pregnancies and their side effects. (E.g., mental retardation, cycles of teen parenting and juvenile delinquency, dependency on welfare, addiction to drugs and alcohol, and societal lack of an effective work force.)

Rural communities must develop school-community partnerships to design community-specific responses consistent with local needs, values, and resources. The use of all informal and formal community resources unique to that particular rural community will strengthen community recognition of the problem and commitment to the solutions designed by local citizens and agencies. Comprehensive efforts designed to enhance student self-esteem and to provide sex education; career, health, academic and mental health counseling; alternate social activities, and facilitate parent-child communication will prevent most teen pregnancies. These efforts will strengthen the physical, mental, and economic health of the rural community involved. The project planning and implementation process itself will strengthen the sense of community.

TEEN PREGNANCY PREVENTION RESOURCES

PUBLICATIONS:

DECIDING ABOUT SEX: THE CHOICE TO ABSTAIN. Network Publications, P.O. Box 1830, Santa Cruz, CA 95061-1830; 408/429-9822. Discusses the physical, emotional, and moral aspects of abstinence.

THAT GROWING FEELING. Planned Parenthood, 1108 16th Street, N.W., Washington, DC 20036; 202/347-8500

A MANUAL ON PROVIDING EFFECTIVE PRENATAL CARE PROGRAMS TO TEENS: How and why we should expand prenatal care services for teens and poor mothers. 158 pp., Children's Defense Fund, 122 C. Street, N.W., Washington, DC 20001.

ADOLESCENT PREGNANCY PREVENTION CLEARINGHOUSE: Six in-depth reports yearly on problems facing the nation's teenagers - and solutions. Solid data, descriptions of model programs, strategies for reaching youths at risk for teen pregnancy, dropping out of school, and other limiting behaviors. Six issues (one year). Children's Defense Fund.

CLEARINGHOUSE REPORTS:

--Preventing children having children (1985)
--Adolescent pregnancy: Whose problem is it? (1986)
--Adolescent pregnancy: What the states are saying (1986)
--Building health programs for teenagers (1986)
--Model programs: Preventing adolescent pregnancy and building youth self-sufficiency (1986)
--Preventing adolescent pregnancy: What schools can do (1986)
--Welfare and teen pregnancy: What do we know? What do we do? (1986)
--Adolescent pregnancy: An anatomy of a social problem in search of comprehensive solutions (1987)
--Child care: An essential service for teen parents (1987)
--Declining earnings of young men: Their relation to poverty, teen pregnancy, and family formation (1987)
--Teens in foster care: Preventing pregnancy and building self-sufficiency (1987)
--Child support and teen parents (1987)
--Teenage pregnancy: An advocate's guide to the numbers (1988)
--Adolescent and young adult fathers: Problems and solutions (1988)
--What about the boys? Teenage pregnancy prevention strategies (1988)

ADOLESCENT PREGNANCY CHILD WATCH MANUAL: By CDF, a step-by-step guide for setting up a local Child Watch project to enable communities to learn more about preventing teen pregnancy. (1984, plus 1988 update and supplement.)

ADOLESCENT PREGNANCY AND PARENTHOOD: A REVIEW OF THE PROBLEM, SOLUTIONS AND RESOURCES: Reviews the problem of early childbearing, discussing some of the most common misconceptions, why it is of major concern and possible solutions. By Gina Adams, Sharon Adams-Taylor, and Karen Pitman. FAMILY RELATIONS, 1989, 38. pp. 223-229.

A HIGH PRICE TO PAY: TEENAGE PREGNANCY IN OHIO: 180 pp., 1987, from CDF.

THE RIGHT START: Preventive health care for preschoolers and pregnant women in Minnesota. 48 pp., 1986, from CDF.

BOOKS:

Ewy, Donna & Rodger. *Teen Pregnancy: The Challenges We Faced, The Choices We Made.* Pruett Publishing, Boulder, CO. Written by 14 pregnant teens for other teenagers contemplating or confronting pregnancy.

Furstenberg, F., Brooks-Gunn, J., and Morgan, S.P. (1987). *Adolescent Mothers in Later Life.* New York: Cambridge Universtiy Press. A 20-year study that has followed 300 young mothers, their children, the fathers, extended family, and children of the children. The authors document how the teen mothers coped.

Moore, K.A., Simms, M.C., and Betsey, C.L. (1986). *Choice and Circumstance; Racial Differences in Adolescent Sexuality and Fertility.* New Brunswick, NJ: Transcation Books/Rutgers. Examines the possible reasons why teenage pregnancy rates among blacks in America are not only significantly higher than among whites, but actually the highest of all developed nations. The question also asked is why some teenagers don't become pregnant, rather than why they do.

Myers, Walter Dean. *Sweet Illusions.* New York: Teachers & Writers Collaborative.

National Academy of Sciences. (1986). *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing* (2 vols.). Washington, DC: National Academy Press. Comprehensive exploration, analysis, and assessment of problems, strategies, and interventions available from the National Academy of Sciences, (202) 334-3313.

Ooms, T. (Ed.). (1981). *Teenage Pregnancy in a Family Context.* Philadelphia: Temple University Press. Focuses on a range of policies concerned with teenage pregnancy, from those aimed at prevention to those providing health care, economic support and social services to the pregnant adolescent and young parent.

PROGRAMS/CURRICULUM:

EASTCON SCHOOL program for young parents and pregnant teens. 18 North Street, Danielson, CT 06239. (203)774-5040.

RURAL ADOLESCENT PREGNANCY PROGRAM: An integrated approach to a community problem. RAPP Program Leader, Windham County Extension Center, P.O. Box 327, Wolf Den Road, Brooklyn, CT 06234. (203)774-4972.

VIDEOS/FILMS/AUDIOTAPES:

IT ONLY TAKES ONCE (1986): Is designed to teach teens and preteens about responsible sexual choices: From saying "no" to using effective contraception. It uses humor and facts to educate the viewers. Included is a discussion guide for teachers. 18:30 minutes, color, price $189.00. Distributed by: INTERMEDIA, 1600 Dexter Ave., N., Seattle, WA 98109. (206)282-7262 or 1-800-553-8336.

HE'S NO HERO (1988): Examines the responsibility of males in sexual decision-making. The target audience is specifically young men. A discussion guide for teachers is included. 18:30 minutes, color, price $189.00. Distributed by INTERMEDIA. 1600 Dexter Ave., N., Seattle, WA 98109. (206)282-7262 or 1-800-553-8336.

WHEN I DREAM: A Children's Defense Fund video that examines the teen pregnancy problem in this country. It gives an inspiring look at the dreams of children and the troubling issues that stand in the way of their aspirations. 13 minutes (VHS).

NEWSLETTER/JOURNALS:

ADOLESCENCE, c/o Libra Publishers, Inc., 2089C Clairmont Drive, Suite

ADOLESCENT SEXUALITY REPORT, c/o Carrera/Spain, P.O. Box 3000, Dept. CS, Denville, NJ 07834. This newsletter provides an opportunity for ongoing dialogues on methods to help adolescents make informed, health decisions about their sexuality.

FAMILY LIFE EDUCATOR, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830; 408/429-9822. Quarterly newsletter featuring articles on contemporary topics, resource reviews, article abstracts, research, legislation, and recent projects.

FAMILY PLANNING PERSPECTIVES, Alan Guttmacher Institute, 111 Fifth Avenue, New York, NY 10003. A bimonthly journal which serves as an interdisciplinary source of information on reproductive health.

FAMILY RESOURCE COALITION REPORT, 320 N. Michigan Avenue, Suite 1625, Chicago, IL 60601. The report is designed to introduce and encourage an exchange of new ideas regarding families.

MEN'S REPRODUCTIVE HEALTH NEWS, Hidden Valley Ranch Center, P.O. Box 661, Capitola, CA 95010. Quarterly newsletter that provides information about male sexuality and reproductive health.

MEN TOO, Planned Parenthood of Pierce County, 813 South K Street, #200, Tacoma, WA 98405, 206/572-8515. Addresses men's issues and resources related to male sexuality, pregnancy, and parenting.

BOYS AND BABIES, GIRLS AND BABIES, 1728 Meadowwood Street, Sarasota, FL 34231; 813/922-7478. Focuses on teaching young girls and boys how to care for babies and includes information on puberty, human sexuality, reproduction, and family life.

CHALLENGES: A YOUNG MAN'S JOURNEY TO SELF-AWARENESS AND PERSONAL PLANNING. CHOICES: A TEEN WOMAN'S JOURNAL FOR SELF-AWARENESS AND PERSONAL PLANNING, Girls' Clubs of America, Inc., National Research Center, 441 West Michigan Street, Indianapolis, IN 46202; 317/634-7546. Two-volume self-help curriculum that addresses the myths and hard realities involved in entering adulthood.

IT TAKES TWO, Salvation Army, Booth Memorial Center, 2794 Garden Street, Oakland, CA 94601; 415/532-3345. This seven-session curriculum for 13- to 17-year-olds uses both single-sex and coed groupings.

LIFE PLANNING EDUCATION, Center for Population Options, 1012 14th Street, N.W., Suite 1200, Washington, DC 20005; 202/347-5700. Integrates sexuality education with vocational education.

PUTTING THE BOYS IN THE PICTURE: A REVIEW OF PROGRAMS AND SERVICES FOR ADOLESCENT MALES, Joy G. Dryfoos, Network Publications, P.O. Box 1830, Santa Cruz, CA 95061-1830; 408/438-4060. Provides an overview of the research, programs, and services that target males in pregnancy prevention. (108 pp., 1988, $19.95).

WORKING WITH TEENAGE FATHERS, Joelle Sander, Teen Father Collaboration, Bank Street College of Education, 610 West 112th Street, New York, NY 10025; 212/663-7200. Guidelines for the development of effective programs for teenage fathers.

RESOURCES/DIRECTORIES/CONTACTS:

NATIONAL MATERNAL AND CHILD HEALTH CLEARINGHOUSE
38th and R Street, N.W.
Washington, D.C. 20057
202/625-8410

THE SUPPORT CENTER FOR EDUCATIONAL EQUITY FOR YOUNG MOTHERS, SCHOOL AND COMMUNITY SERVICES
ACADEMY FOR EDUCATIONAL DEVELOPMENT
100 Fifth Avenue
New York, NY 10011

SUPPORT CENTER FOR SCHOOL-BASED CLINICS
5650 Kirby Drive, Suite 203
Houston, TX 77005
713/664-7400

CENTER FOR POPULATION OPTIONS
1012 14th Street, N.W.
Washington, D.C. 20005
202/347-570

CHILDREN'S DEFENSE FUND (CDF)
122 C Street, N.W., Suite 400
Washington, D.C. 20001
202/628-8787

NATIONAL INSTITUTE FOR ADOLESCENT PREGNANCY AND FAMILY SERVICES
Seltzer Hall, Room 409
Temple University
1700 North Broad Street
Philadelphia, PA 19121
215/787-6208

NATIONAL ORGANIZATION ON ADOLESCENT PREGNANCY AND PARENTING (NOAPP)
P.O. Box 2365
Reston, VA 22090
703/435-3948

ROBERT WOOD JOHNSON SCHOOL-BASED ADOLESCENT HEALTH CARE PROGRAM
Children's Hospital National Medical Center
111 Michigan Ave., N.W.
Washington, DC 20010
202/745-2000

SCHOOL HEALTH PROGRAMS
University of Colorado Health Sciences Center
4200 East Ninth Ave., C-287
Denver, CO 80262
303/394-7435

PLANNED PARENTHOOD FEDERATION OF AMERICA, Inc.
810 Seventh Avenue
New York, NY 10019
212/541-7800

SEX INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES (SIECUS)
32 Washington Place
New York, NY 10003
212/673-3850

ACADEMY FOR EDUCATIONAL DEVELOPMENT (AED)
100 Fifth Avenue
New York, NY 10019
212/243-1110

THE ALAN GUTTMACHER INSTITUTE (AGI)
360 Park Avenue
New York, NY 10003
212/254-5656

AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS, AND THERAPISTS (AASECT)
Eleven Dupont Circle, N.W.
Suite 220
Washington, DC 20036
202/462-1171

ASSOCIATION OF JUNIOR LEAGUES, Inc. (AJL)
825 Third Avenue, 27th Floor
New York, NY 10022
212/355-4380

CENTER FOR EARLY ADOLESCENCE (CEA)
The University of North Carolina
Carr Mill Mall, Suite 223
Carrboro, NC 27510
919/966-1148

NATIONAL MARCH OF DIMES
1275 Mamaraneck Avenue
White Plains, NY 10605
914/428-7100

THE NATIONAL URBAN LEAGUE (NUL)
500 East 62nd Street
New York, NY 10021
212/310-9134

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